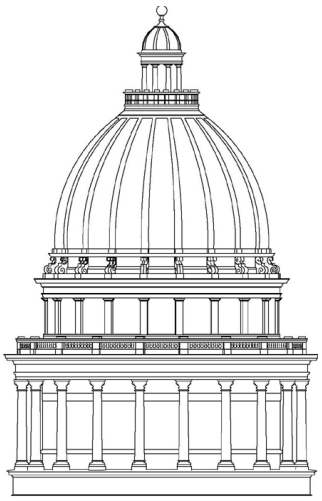
REPORT TO THE

UTAH LEGISLATURE

Number 2012-03



An In-Depth Follow-Up of Utah Medicaid's Implementation Of Audit Recommendations

January 2012

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH
Office of the Legislative Auditor General

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JOHN M. SCHAFF, CIA
AUDITOR GENERAL

January 2012

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **An In-Depth Follow-Up of Utah Medicaid's Implementation of Audit Recommendations** (Report #2012-03). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

John M. Schaff

John M. Schaff, CIA
Auditor General

JMS/lm

Digest of
An In-Depth Follow-Up of Utah Medicaid's Implementation of Audit Recommendations

Chapter I: Introduction

Continuing legislative concern with the overall operation of Utah's Medicaid system has resulted in a number of audits over the last three years. This report provides a second in-depth follow-up on two of our previous reports: *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* and *A Performance Audit of Utah Medicaid Managed Care*. In addition, this report provides the first in-depth follow-up of *A Performance Audit of Utah Medicaid Provider Cost Control*, and also addresses additional recommendations in the first follow-up report *A Follow-up of Utah Medicaid's Implementation of Audit Recommendations*. Of the 63 recommendations reported in the past audits, 41 have been implemented and the other 22 are in the process of implementation. The reports have also produced substantial cost savings, as can be seen in the following figure.

Cost Savings Due to Legislative Audits. Reported savings from Utah Medicaid and the Office of Inspector General (OIG) that relate in whole or in part to recommendations contained in past Medicaid reviews.

	Reported Cost Savings (In millions)
Audit #1: Fraud, Waste and Abuse Controls	$18.1
Audit #2: Utah Medicaid Managed Care	18 to 24
Audit #3: Provider Cost Control	3.4
Total Potential Annual Savings	**$39.5 to $45.5**

Source: For reports #1 and #3 - Utah Medicaid program and the Office of Inspector General. (The numbers have not been audited by the Office of the Legislative Auditor General (OLAG)). For report #2 – cost savings calculated from projections in the original audit along with updated information from Utah Medicaid.

In addition to the above savings, $400,000 has been recovered as of December 2, 2011, by a cost recovery contractor hired in conjunction with one of our past audits. Even more, the contractor has identified an additional $23 million for possible recovery. The actual amount recovered of those funds will be determined in the administrative hearing process. System wide Medicaid savings through cost avoidance and cost recovery could reach a half-billion dollars or more over the next ten years.

Chapter II: Follow-Up of Report 2009-12: *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* (August 2009)

Cost Avoidance Activities Have Improved. The 2009 report placed a substantial importance on Utah Medicaid cost avoidance activities. We are particularly encouraged by the department's recent improvements to the prior authorization process. The process now has more management oversight, which appears to help control Medicaid program costs.

Office of Inspector General Is Positioned to Increase Cost Recovery. Most of the recommendations dealing with improved cost recovery efforts are being addressed by the newly created Office of Inspector General (OIG). This office has only been in existence for a few months and, as such, is working on implementing Legislative audit recommendations dealing with cost recoveries.

Chapter III: Follow-Up of Report 2010-01: *A Performance Audit of Utah Medicaid Managed Care* (January 2010)

Cost Reductions Continue to Occur in Managed Care. Utah Medicaid has begun implementing the cost control strategies outlined in the audit report. Further cost control strategies, which are in harmony with those discussed in the audit, will be implemented with S.B. 180, passed during the 2011 Legislative General Session.

Managed Care Oversight Is Improving. Utah Medicaid continues to make progress in improving its oversight over the managed care plans. Last year, most oversight-related recommendations were still categorized as in process. This year, many recommendations have been implemented, and the passage of S.B. 180 (2011 Legislative General Session) will further help in the implementation of these recommendations.

Chapter IV: Follow-Up of Report 2010-16: *A Performance Audit of Utah Medicaid Provider Cost Control* (December 2010)

Efforts to Control Utah Medicaid Payment Systems Are Ongoing. The December 2010 report found that Utah Medicaid's identification and fund recovery system is hindered by system design problems and insufficient policies and procedures. Consequently, internal systems can unintentionally allow waste and abuse to occur in the Utah Medicaid program. Utah's Medicaid program is working to control and correct these internal problems.

The Legislature, Acting on Independence Concerns, Created the Office of Inspector General. The December 2010 report examined the independence of the oversight functions over the program integrity and audit departments. The audit found continuing independence concerns that led us to question if the structure then in place could adequately review the nearly $2 billion in Utah Medicaid funds. We consequently recommended the creation of an independent Office of Inspector General. The Legislature created this office in the 2011 Legislative General Session.

Chapter V: 2010 *Follow-Up of Utah Medicaid's Implementation of Audit Recommendations*

Provider Enrollment Can Bolster Controls, and Extrapolation Should Be Allowed in Provider Audits. During our in-depth follow-up last year, two additional recommendations were made, which were aimed at better controlling provider enrollment and increasing collections through extrapolation. Both of the recommendations are now implemented.

REPORT TO THE

UTAH LEGISLATURE

Report No. 2012-03

An In-Depth Follow-Up of Utah Medicaid's Implementation Of Audit Recommendations

January 2012

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Chapter I
Introduction

Continuing legislative concerns with the overall operation of Utah's Medicaid system have resulted in a number of audits over the last three years. This report provides a second in-depth follow-up on two of our previous reports: *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* and *A Performance Audit of Utah Medicaid Managed Care*. In addition, this report provides the first in-depth follow-up of *A Performance Audit of Utah Medicaid Provider Cost Control*. This report also addresses additional recommendations made during the first follow-up report *A Follow-up of Utah Medicaid's Implementation of Audit Recommendations*. Of the 63 recommendations reported in the past audits, 41 have been implemented and the other 22 are in process of implementation.

This report provides an in-depth follow-up of four previous Medicaid reports.

Past Legislative Audits Have Provided Substantial Savings to the State

Recommendations made in the past four audits appear to be producing significant cost savings for the state. Estimates from our previous reports, along with data provided by the Utah Medicaid program and the newly established Office of Inspector General (OIG), show that cost savings ranging from $39.5 million to $45.5 million either have occurred or should occur. Figure 1.1 illustrates reported cost savings.

Reported cost savings are between $39.5 million and $45.5 million.

Figure 1.1 Cost Savings Due to Legislative Audits. Reported savings are from Utah Medicaid and the OIG and relate in whole or in part to recommendations contained in past Medicaid reviews.

	Reported Cost Savings (In millions)
Audit #1: Fraud, Waste and Abuse Controls	$18.1
Audit #2: Utah Medicaid Managed Care	18 to 24
Audit #3: Provider Cost Control	3.4
Total Potential Annual Savings	**$39.5 to $45.5**

Source: For report #1 and #3 – Utah Medicaid program and the Office of Inspector General (OIG). (The numbers have not been audited by the Office of the Legislative Auditor General (OLAG)). For report #2 – cost savings calculated from projections in the original audit along with updated information from Utah Medicaid.

Reported savings could equal almost $500 million over a 10-year period if current savings continue each year.

In addition to the above savings, $400,000 has been recovered as of December 2, 2011, by a cost recovery contractor hired in conjunction

with one of our past audits. Even more, the contractor has identified an additional $23 million for possible recovery. The actual amount recovered of those funds will be determined in the administrative hearing process. System wide Medicaid savings through cost avoidance and cost recovery could reach a half-billion dollars or more over the next ten years.

It is important to point out that this follow-up audit reports cost savings identified by the Utah Medicaid program and the OIG that have not been verified. We also note that the new OIG is conducting a quality assurance review on its reporting system and methodology, which could result in an adjustment in that office's stated savings. Nevertheless, we believe that with the new activity and focus on saving Medicaid funds, the numbers appear reasonable. Greater detail and explanation of cost savings are found in the remainder of the report.

Four Previous Reports Are Contained In This Follow-Up Report

This report is divided into four subsequent chapters, one for each previous report. The four reports are numbered throughout this follow-up in the following manner:

- **Report #1:** *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* (Report 2009-12)
- **Report #2:** *A Performance Audit of Utah Medicaid Managed Care* (Report 2010-01)
- **Report #3:** *A Performance Audit of Utah Medicaid Provider Cost Control* (Report 2010-16)
- **Report #4:** *A Follow-Up of Utah's Medicaid Implementation of Audit Recommendations* (Report 2010-14)

A brief description of each report can be found below.

A Performance Audit of Fraud, Waste, And Abuse Controls in Utah's Medicaid Program

This report, issued in August 2009, focused on what was then known as the Bureau of Program Integrity (BPI), whose function was to identify and recover inappropriate payments from provider fraud, waste, or abuse. In response to our concerns about the independence of BPI and its internal auditors, the Legislature created an independent Office of Inspector General (OIG) during the 2011 Legislative General Session. The purpose of the OIG is to independently audit Utah's Medicaid program and perform program integrity functions. During this review, we found that improvements have been made in the areas of cost recovery and cost avoidance.

The August 2009 report found that improvements were needed to the controls over Medicaid fraud, waste, and abuse.

A Performance Audit Of Utah Medicaid Managed Care

Issued in January 2010, this report focused mainly on the Bureau of Managed Health Care, which oversees the contracted managed health care plans utilized by Utah Medicaid. We found that insufficient oversight had been provided to these plans, and substantial savings were possible through increased controls. The audit also looked at other ways of implementing cost-saving options by reducing utilization of services or finding low-cost alternatives. We found that significant work has been done on most of the recommendations.

The January 2010 report found that substantial savings are achievable in Utah Medicaid's managed care programs.

A Performance Audit of Utah Medicaid Provider Cost Control

Issued in December 2010, this report focused on illustrating occurrences of fraud, waste, and abuse in Utah's Medicaid program. This report was initiated because of a comment from the former executive director of the Department of Health (DOH) that fraud, waste, and abuse levels in Utah were lower and not comparable to the levels in other states. Accordingly, this report illustrated several locations where fraud, waste, and abuse were occurring, including a health clinic that was owned and operated by DOH.

The December 2010 reported several areas where fraud, waste, and abuse were occurring.

A Follow-Up of Utah Medicaid's Implementation of Audit Recommendations

This report presented an in-depth follow-up to two Medicaid audits, *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* (Report 2009-12), and *A Performance Audit of Utah Medicaid Managed Care* (Report 2010-01). This report is included in this follow-up because it contained additional DOH recommendations.

Description of Implementation Status And Legend of Recommendations

A recommendation's implementation status can be categorized in one of the following four ways:

- Implemented – The recommendation has been completed in the manner intended.
- In progress – The department has begun making the necessary improvements, but the improvements have not yet been completed. The department intends to continue working toward implementation.
- Partially implemented – The department has taken steps toward implementing the recommendation but has not fully completed it and has no intention to take further action.
- Not implemented – Either the department has decided not to implement the recommendation or they are waiting for some other action to take place.

This report uses a color coding system to identify the entity to which the recommendation was given:

The report uses a color coding system for each recommendation: green – DOH, blue – OIG, gray – Legislature.

- Green – DOH/Utah Medicaid
- Blue – OIG
- Gray – Legislature

Please note that some of the recommendations may pertain to more than one or all of the above mentioned groups. In these cases we have used the color corresponding to what we consider to be the primary respondent to the recommendation.

Audit Scope and Objectives

We were asked to perform an in-depth follow-up on four previous Utah Medicaid reports. This audit had two primary objectives:

- Follow-up on the implementation status of recommendations.
- Identify areas where further improvements can be made.

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Chapter II
Follow-Up of Report 2009-12: *A Performance Audit of Fraud, Waste, And Abuse Controls in Utah's Medicaid Program* (August 2009)

Our 2009 report, *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program,* covered three primary areas:

- Cost avoidance
- Cost recovery
- Independence of oversight functions

The report's recommendations called for improved controls that would ultimately save taxpayer funds. Based on information provided to us by the newly created Office of Inspector General (OIG) and the Department of Health (DOH), implementation of the recommendations has significantly safeguarded taxpayer funds. Figure 2.1 provides an estimate of program savings.

Figure 2.1 Estimated Utah Medicaid Program Savings. The following are estimated program savings for Fiscal Year 2011. In some instances, these program savings have likely been used to offset budget reductions.

Savings Type	Savings (in millions)
Costs Recovered	$12.8[1]
Costs Avoided	5.3[2]
Total	**$18.1**

Source: Utah Medicaid program and OIG. These numbers have not been audited by OLAG. Cost avoidance numbers are still being refined.
1: This number was calculated by subtracting the reported cost savings amount in our August 2009 report (FY 2008) from cost savings reported to us during this follow-up (FY 2011). Utah Medicaid reports that this amount includes all funds recovered by the OIG, which the OIG reported as $11.1 million. This was the best available data we were able to obtain; it may need to be corrected in the future.
2. This number includes $1.4 million in savings from the prepayment vendor and $3.9 million reported by the OIG.

It is estimated that implementing the 2009 audit recommendations resulted in savings of $18.1 million in 2011.

The report challenged the Utah Medicaid program to enhance cost avoidance and set a goal, based on national statistics, to increase recoveries by $20 million. It appears that the programs, systems, and processes that have been put in place after the audit are now working to increase collections. These new systems, coupled with estimated

savings from a new cost recovery contractor, are helping Utah Medicaid protect valuable program dollars. As of December 2, 2011, the cost recovery contractor has recovered about $400,000 and has identified and additional $23 million for recovery. The identified funds must still withstand the test of the hearing process before they can be considered recovered. We are encouraged by the progress that has been made to better guard and protect Medicaid funds.

When we conducted our first follow-up of this report last year, we found that 5 recommendations (20 percent) were implemented, 16 (64 percent) were in process, and 4 (16 percent) had been partially implemented.

This year, we found a significantly higher number of implemented recommendations. In addition, the Legislature took action on some of the partially implemented recommendations by changing state statute, which allowed the recommendations to be fully implemented. The current status of this report's recommendations is as follows:

Currently, the status of the 2009 report's recommendations is 60 percent implemented and 40 percent in process.

- Implemented – 15 (60 percent)
- In process – 10 (40 percent)

Most of the recommendations that are still in process deal with aspects of the program that now fall under the newly created OIG. The Legislature created the OIG (H.B. 84 fourth substitute, during the 2011 Legislative General Session) to be an independent body responsible for auditing the Utah Medicaid program and overseeing the control and recovery of Medicaid funds from fraud, waste, and abuse. Since this office is new, it is understandable that they are still in the process of developing their oversight programs.

Cost Avoidance Activities Have Improved

The 2009 report placed substantial importance on Utah Medicaid cost avoidance activities. Specifically, the audit report emphasized two cost avoidance activities:

- Improved prior authorization oversight and control. Prior authorization is the approval of non-covered, specialized, and costly procedures before they are conducted.
- Improved provider enrollment oversight and control. Utah Medicaid used to have a more relaxed and open provider enrollment process.

Please note that the prior authorization process still resides within the Utah Medicaid program and is not under the direction of the OIG.

Prior Authorization Oversight And Controls Have Improved

We are encouraged by the department's improvements to the prior authorization process. The process has more management oversight, which appears to help control Medicaid program costs. To fully gauge the impact of the new prior authorization process, a complete audit would need to be conducted. Figure 2.2 shows the implementation status of each prior authorization process recommendation.

All recommendations regarding the prior authorization process from the 2009 audit have been implemented.

Figure 2.2 Status of Recommendations from Chapter II, Report #1. All the recommendations dealing with the prior authorization process have now been implemented.
(Recommendation color code: green – DOH)

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that the Bureau of Program Integrity (BPI) establish clear guidelines for when a prior authorization request should be reviewed by the appropriate utilization review committee.	Implemented	Implemented	No change
We recommend that BPI management ensure prior authorization nurses receive regular training on how to review prior authorization requests.	Implemented	Implemented	No change
We recommend that BPI management ensure prior authorization nurses present the following to the appropriate UR committee: a. Non-covered procedures that do not have established	In process	Implemented	A control has been put in place to ensure that nurses are appropriately presenting cases to the oversight committee.

Recommendation	2010 Status	2011 Status	2011 Explanation
criteria b. Requests for procedures that may require an exception to policy			
We recommend that the Health Care Financing (HCF) establish criteria for the following circumstances: a. Procedures for which HCF does not agree with InterQual criteria b. Common prior authorization requests, such as circumcision	In process	Implemented	New criteria have been established. However, management recognizes that criteria updates are an ongoing endeavor and has created procedures to accomplish this.
We recommend that more management oversight be given to the prior authorization process. The prior authorization manager should regularly monitor prior authorization nurses to ensure adherence to statute, administrative rule, HCF policy, and established criteria when evaluating a prior authorization request.	In process	Implemented	Last year management was working to hire new staff to oversee this process. Hiring has now been completed and regular monitoring is occurring. A new database tool was also created to help with management oversight.
We recommend that the HCF adequately document all changes to policy.	Implemented	Implemented	No change.

The 2009 report identified that nurses had little supervision or few controls placed over their individual approval of prior authorization requests. Consequently, questionable, non-covered procedures were being approved (e.g., nose and face reconstructions and a breast augmentation). Their unilateral approval of non-covered procedures was resulting in unnecessary medical costs.

Improvements to the prior authorization process include a clarified policy, decision reviews, and supervisor training.

During this follow-up review, we found that the recommendations made in this report have helped improve controls and ensure that only authorized and medically necessary procedures are being approved. Specifically, department management of the prior authorization process now includes the following:

- Clarifications to policy that more clearly delineate between the types of cases that require committee approval and those that can be unilaterally approved by a nurse
- Regular sampling and review of prior authorization decisions by a nurse's supervisor
- Regular training and oversight requirements for the prior authorization supervisor
- Streamlining and reorganizing the committee approval process of those prior authorization requests that can be unilaterally approved by a nurse.

Also reported in the 2009 audit was the need to clarify policies and procedures. Some medical policies and criteria were not available to the nurses, or nurses were given contradictory criteria. The 2009 report states:

> the electronic manual does not have criteria for either circumcisions or sleep study procedures . . . additionally one prior authorization nurse said that she does not use the electronic manual because it is inconsistent with the providers' manual.

To help correct this problem, management teams from the prior authorization and Medicaid policy sections meet weekly to ensure that criteria are up to date and accurate in order to serve nurses' needs. A workgroup has also been recently implemented to work on modifications and/or development of medical criteria.

Legislative Action Has Resulted in Provider Enrollment Improvements

Changes made by the Legislature last year positively affected the success of the provider enrollment process, which, in turn, helped promote more accountability and integrity in the Medicaid program. This year, the Legislature passed two more bills (H.B. 84 and H.B. 358) that further promoted controls over Utah Medicaid provider enrollment.

H.B. 84 gave the Office of Inspector General access to the controlled substance database to help prevent, detect, and collect lost Utah Medicaid funds.

Specifically, the Legislature gave the OIG access to the controlled substance database. H.B. 84 clarified that the OIG has access to the controlled substance database as part of its mission to prevent, detect,

and collect Utah Medicaid funds lost through fraud, waste, and abuse. Figure 2.2 shows the status of recommendations pertaining to increased controls over the provider enrollment process.

Figure 2.3 Status of Recommendations from Chapter III, Report #1. Most of the recommendations from this chapter have now been implemented.
(Recommendation color code: green – DOH and blue – OIG)

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that HCF determine the feasibility of putting provider enrollment in the Bureau of Program Integrity.	Implemented	Implemented	No change
We recommend that provider enrollment develop its own standards and policies for enrolling new providers to ensure they are properly precluding fraudulent and other high-risk providers.	Implemented	Implemented	No change
We recommend that provider enrollment consider provider need when considering providers with disciplines, for providers not automatically precluded by policy.	In process	Implemented	DOH is better controlling provider enrollment by disenrolling those providers that have not billed for 24 months.
We recommend that the Legislature consider the merits of extending access of the controlled substance database to BPI. If access is granted, BPI should develop and institute controls to ensure providers are billing Medicaid correctly and that prescriptions are appropriate in regards to frequency and dosage.	Partially implemented	In process	This recommendation was changed to in-process after the Legislature granted full access of the controlled substance database to BPI (now OIG). OIG recently hired an individual who is building modules to use this information.

Three out of the four recommendations from Chapter III of Report #1 have been implemented.

The OIG has hired a new staff person trained in data analytics. This individual has determined various uses for the controlled substance database and is currently in the process of developing modules to use this data. Once these modules are in place, the OIG believes it will produce information that can lead to the recovery of inappropriate payments.

Office of Inspector General Is Positioned to Increase Cost Recovery

Most of the recommendations dealing with improved cost recovery efforts are being addressed by the newly created Office of Inspector General (OIG). This office has only been in existence for a few months and, as such, is working on implementing Legislative audit recommendations dealing with cost recoveries.

Cost Recovery Contract Is Helping Recoup Inappropriate Payments

The new OIG utilizes a cost recovery contract that was developed before the OIG office was created. Under this agreement, a contractor reviews past claims data to identify instances where inappropriate payments were made. The cost recovery contract was developed by the DOH's internal auditors (now under the OIG's authority) with some collaboration from our office. The contract appears to be working well. Over the last year, the contractor has been working on identifying inappropriate payments. To date, the contractor has identified about $23 million, though it is important to note that these funds must still proceed through a settlement hearing process before they can be recovered. Figure 2.3 shows the status of the recommendations dealing with increased cost recovery efforts.

With the help of a contractor, OIG is working to identify instances where inappropriate payments were made.

Figure 2.4 Status of Recommendations from Chapter IV, Report #1. Most of these recommendations are still in process of being implemented.
(Recommendation color code: blue – OIG)

Six out of the seven recommendations from Chapter IV of Report #1 are still in process.

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that BPI either fix the current SURS system or purchase a working analytical tool that can systematically review claims for fraud, waste, and abuse.	In process	In process	A full analytical tool is still not in place. OIG is using targeted queries to review some claims.
We recommend that BPI begin tracking the exact percentage of total program expenditures recovered.	In process	In process	OIG is in the process of developing a new tracking system.
We recommend that BPI design a system that allows them to better track, pull, and sort recovery data.	In process	In process	BPI had a new system built. The OIG director feels it lacks some needed modules. OIG is in

Recommendation	2010 Status	2011 Status	2011 Explanation
			the process of completing this project.
We recommend that BPI develop a staff cost allocation and assignment system that can effectively and efficiently allocate staff time and resources.	In process	In process	OIG is in the process of building a new staff allocation tool.
We recommend that BPI track its employees' return on investment.	In process	In process	OIG has begun tracking the overall ROI of the office, but has not yet tracked individual employees ROI.
We recommend that BPI develop specific performance measures and develop rating metrics, and then track adherence to these goals.	In process	In process	OIG is developing these metrics.
We recommend that BPI report annually to the Legislature and Governor on their cost avoidance and cost recovery efforts.	In process	Implemented	The first annual report has been given.

OIG reports a total of $15 million in cost savings in 2011.

The OIG reported to the Legislature in its first annual report that they have collected about $11.1 million ($1 million from its audit functions and $10.1 million from program integrity). The OIG also reports about $3.9 million in cost savings, for a total savings of about $15 million.

More Medicaid Dollars Are Being Reviewed, But More Can Still Be Done

Our 2009 audit reported that "about 95 percent of Medicaid funds, or $1.5 billion, receive little to no systematic, consistent oversight by the Bureau of Program Integrity (now the OIG)." The audit determined that "this lack of oversight by [program integrity] has placed valuable program dollars at risk and has undermined the recovery effort."

OIG and the recovery contractor are now conducting more reviews of the Utah Medicaid program.

The OIG has begun targeted reviews on more aspects of the Medicaid program. The recovery contractor, as previously mentioned, has also reviewed, in greater depth, more areas of the Medicaid program. We are encouraged with these additional reviews.

However, a fully functioning analytical tool is still not in place. This recommendation was considered important as a means to get broad oversight coverage over all Medicaid program funds. An analytical tool, or fraud and abuse detection system (FADS) is a specially designed system that uses sophisticated analysis and algorithms to detect, prevent, and recover funds lost to fraud, waste, and abuse.

In 2010, Utah Medicaid issued a request for proposals (RFP) that addressed several different needed components of program integrity functions, including an analytical tool (FADS). However, the RFP bundled a number of unique components that are not commonly packaged together. As a result, only one company responded to the RFP. This respondent was not deemed credible.

The current plan is to use a basic analytical tool provided by federal Medicaid, coupled with specific targeted queries built by the OIG, until a fully functioning tool is provided with the new rebuild of Utah Medicaid's payment software in a few years. Figure 2.5 shows the status of the recommendations made dealing with increased oversight of Medicaid program funds.

OIG does not yet have an advanced fraud and abuse detection system in place.

Figure 2.5 Status of Recommendations from Chapter V, Report #1. Two recommendations from this chapter are still in the process of being implemented.
(Recommendation color code: blue – OIG)

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that BPI develop a systematic methodology that allows them to review all Medicaid dollars in inpatient and non-inpatient program areas for fraud, waste, and abuse.	In process	In process	OIG reports doing targeted reviews throughout the Medicaid program. They are now working on a systematic methodology.
We recommend that BPI provide adequate oversight and ensure Medicaid dollars are being reviewed for fraud, waste, and abuse in all other contracted Medicaid services.	In process	In process	OIG's targeted reviews along with the reviews of an independent contractor have increased the oversight over more areas of Medicaid funds. However, there are still some areas not receiving a full review.
We recommend that BPI consider using statistical sampling or extrapolation in their audits of providers.	In process	Implemented	A new rule has been adopted and will soon be implemented in provider audits.
We recommend that BPI conduct more financial audits of providers.	In process	Implemented	OIG completed some audits of providers last year.

Two out of four recommendations from Chapter V of Report #1 have been implemented.

We are encouraged with the new rule that was written and recently signed by DOH that deals with the use of extrapolation of statistical sampling in provider audits. Other states have reported success with this audit tool. As reported in the 2009 audit, Texas claimed a 2,016 percent recovery increase using extrapolation – $367,106 collected by using extrapolation, compared to just $17,351 collected without using extrapolation. Oklahoma reported that without using extrapolation, they would have recovered about $37,056 over 18 months. However, using extrapolation, they recovered about $523,713 (a 1,313 percent increase).

Creation of OIG Has Bolstered Independence, Full Impact of OIG Not Yet Known

The 2009 audit identified several significant problems with the independence of Utah Medicaid's program integrity and internal audit functions. The concerns outlined in the report, along with additional concerns reported in a December 2010 audit, resulted in a recommendation to create an independent OIG. The Legislature responded to this recommendation and created an independent OIG during the 2011 Legislative General Session. The creation of this office, along with internal changes made at the DOH, resulted in most of the recommendations being implemented. Figure 2.6 shows the implementation status of the recommendations that deal with increased audit and program integrity independence.

Creation of the OIG has resulted in more independent oversight of Utah Medicaid.

Figure 2.6 Status of Recommendations from Chapter VI, Report #1. All but one recommendation from this chapter has been implemented. The one recommendation that is still in process is due to the new OIG ramping up its programs and staff.
(Recommendation color code: gray – Legislature, green – DOH and blue – OIG)

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that the post-payment review function and all other associated areas within BPI report to either the agency head or an independent board.	Partially implemented	Implemented	The Legislature created an independent OIG, which is now conducting these functions.
We recommend that DOH comply with ***Utah Code*** and restructure the reporting relationship of the internal auditors so that the director of internal audit reports either to the agency head of DOH or an independent board.	Partially implemented	Implemented	Creation of the OIG corrected this concern for auditors assigned to that group. DOH has also corrected the reporting relationship for auditors housed there.
We recommend that the Medicaid auditors report to either the director of program integrity, the director of internal audit, or a combination of both so they can achieve more organizational independence.	Partially implemented	Implemented	All audit positions have been correctly classified. Employees not doing audit work will be reclassified.

Three out of four recommendations from Chapter VI of Report #1 have been implemented.

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that the DOH executive director immediately direct the internal auditors to conduct performance audits of the Medicaid program and ensure that regular, consistent internal performance audits are conducted of Utah's Medicaid program.	In process	In process	Currently there are several unfilled auditor positions both at the OIG and at DOH. Both agencies feel Medicaid auditing will increase after positions are filled.

The only recommendation above that has not been implemented deals with internal auditors conducting consistent performance audits of the Utah Medicaid program (some of those auditors are now in the OIG). We believe that this recommendation is still in process due to the fact that many audit positions both in the OIG and in the internal audit group at DOH are vacant and have been vacant for a number of months.

Chapter III
Follow-Up of Report 2010-01: *A Performance Audit of Utah Medicaid Managed Care* (January 2010)

The Utah Medicaid program appears to have actively implemented the recommendations made in Report 2010-01: *A Performance Audit of Utah Medicaid Managed Care*. It appears the implementation of these recommendations has led and will continue to lead to cost savings in the managed care program (now referred to as accountable care).

Utah Medicaid has actively implemented the Managed Care audit recommendations.

Initial cost savings estimates presented in our original Managed Care report totaled annual savings of $13 million to $19 million ($6 million-$12 million in managed care plan adjustments and $7 million to ER payment changes). In addition, we recommended that Utah Medicaid change its reimbursement mechanism by moving away from a percent-of-charges to a revenue-code fee schedule. As a result of implementing this recommendation, Utah Medicaid reports about $5 million in annual savings. Figure 3.1 shows this costs savings.

Figure 3.1 Estimated Cost Savings from Audit-Recommended Payment Adjustments. Cost savings from the implementation of recommendations made in the 2010 managed care audit are the result of changes in managed care reimbursement procedures.

Source of Savings	Annual Estimated Savings (In millions)
Managed Care Plan Cost Savings	$ 6 to $12
Correct ER Payment Errors	7
Move Away from Percent-of-Charges Methodology	5
Total	**$18 to $24**

Source: Utah Medicaid program and estimated savings from "A Performance Audit of Utah Medicaid Managed Care"

It is estimated that savings of $18 million to $24 million can be achieved through implementation of audit recommendations.

Senate Bill 180, passed during the 2011 Legislative General Session, should also have significant impact on cost control in managed care. S.B. 180 was ultimately turned into a waiver by Utah Medicaid and was submitted to federal Medicaid (Center for Medicare and Medicaid Services or CMS) and is currently under review. If

CMS approves the waiver, then Utah Medicaid can begin implementing its provisions of S.B. 180.

The previous follow-up to this report detailed 5 recommendations (19 percent) as implemented, 20 (74 percent) as in process, 1 (4 percent) as partially implemented, and 1 (4 percent) as on hold. This year, the much higher implementation rate shows Utah Medicaid has been working on these recommendations. The current status is shown below:

Currently, 67 percent of managed care recommendations have been implemented and 33 percent are in process.

- Implemented – 18 (67 percent)
- In process – 9 (33 percent)

Cost Reductions Continue to Occur in Managed Care

Prior to our 2010 report on managed care, the state's managed care program relied primarily on its private, contracted managed care organizations to control provider charges and recipient utilization. Insufficient Utah Medicaid and contractor oversight led to higher than necessary costs for managed care's nearly 70,000 recipients. Additionally, 110,000 Utah Medicaid recipients were on a fee-for-service program; the state needed to develop strategies to ensure that the lowest cost was being achieved.

Cost Controls for Managed Care Are Improving

S.B. 180 includes the implementation of additional managed care cost control strategies.

Utah Medicaid has begun implementing the cost control strategies outlined in the audit report. In addition, further cost control strategies, that are in harmony with those discussed in the audit, will be implemented with S.B. 180. This bill generally provides for the following new strategies (as reported by Utah Medicaid):

- Restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that maintain or improve recipient health status.
- Restructure the program's cost-sharing provisions and other incentives to reward recipients for personal efforts to maintain or improve their health, and use providers who deliver appropriate services at the lowest cost.

- Pay providers for episodes of care rather than individualized services.
- Limit the rate of growth in per-patient-per-month General Fund expenditures for the Medicaid program to the rate of growth in General Fund expenditures for all other programs.

Figure 3.2 shows the status of our recommendations in Chapter 2 of the Managed Care audit.

Most recommendations from Chapter II of the managed care audit are still in process.

Figure 3.2 Status of Recommendations from Chapter II, Report #2. Most recommendations from this chapter are still in process. This is due to changes that were brought about by S.B. 180 of the 2011 Legislative General Session. Utah Medicaid is actively working to implement these recommendations.
(Recommendation color code: gray – Legislature and green – DOH)

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that Utah Medicaid appropriately incentivize the health plans to reduce utilization and contain costs.	In process	In process	S.B. 180 changes the way this occurs but should still accomplish the initial goal. Utah Medicaid is waiting to hear from CMS on approval of the new program.
We recommend that Utah Medicaid develop a Request for Proposal (RFP) to encourage more managed care organizations to enter the state.	On hold	In process	An RFP was not issued, but a new health plan has shown interest in coming to the state and Utah Medicaid is in negotiations with this plan.
We recommend that Utah Medicaid review ways to achieve more cost control in its Select Access plan. This could be achieved by turning the population over to a managed care plan, or through other proven, cost-effective methods.	In process	In process	S.B. 180 is moving the Select Access plan to a fully capitated plan.
We recommend the Legislature provide policy guidance to Utah Medicaid on appropriate cost control reimbursement methods and require Medicaid to submit progress reports to them on this issue.	In process	Implemented	With a combination of enacting legislation aimed at controlling costs and improving oversight and re-assigning our office to complete follow-up work, the Legislature has implemented this recommendation.

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that Utah Medicaid review the viability and potential benefits of expanding managed care into more areas of the state. The Legislature should use this information to provide policy guidance on this issue.	In process	In process	One health plan is expanding coverage into several more rural counties. Additionally, Utah Medicaid suspects a new health plan they are in negotiations with could further expand this coverage to the rural areas of the state.
We recommend that Utah Medicaid seek a waiver from Federal Medicaid to develop a method of auto-assigning members to the lowest-cost managed care plan after a recipient's open enrollment period has expired.	Partially implemented	Implemented	With the new waiver that Utah Medicaid developed based on S.B. 180, they report to us that they are revisiting this concept and seeking approval.
We recommend that Utah Medicaid review methods of accelerating the process of assigning Medicaid recipients to a managed care plan.	Implemented	Implemented	No change

Cost Control in Managed Care Is Necessary

Cost control in the managed care program (now called accountable care) is essential. Utah Medicaid setting appropriate benchmarks of costs and working with the managed care group to achieve the benchmarks should be a fundamental part of the managed care structure.

Utah Medicaid is working to improve utilization and cost oversight of contracted managed care plans.

The 2010 audit found that Utah Medicaid had not "provided adequate oversight over the managed health care plans' utilization and cost." The report's recommendations were made to help ensure that system recipient utilization and procedure costs would be given appropriate oversight in the future. It appears that Utah Medicaid is moving in that direction. Figure 3.3 shows the status of recommendations from Chapter 3 of the Managed Care audit.

Figure 3.3 Status of Recommendations from Chapter III, Report #2. Utah Medicaid has been actively working on these recommendations. All but one of the recommendations from this chapter are implemented. (Recommendation color code: gray – Legislature and green – DOH)

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that, in the future, Utah Medicaid better compare Utah managed care plans through risk-adjusted analyses. Utah Medicaid should also benchmark Utah's plans to other well-managed plans.	In process	Implemented	Utah Medicaid has continued the study conducted during the audit. The actuary has been able to use this study to help contain and reduce cost in managed care.
We recommend that Utah Medicaid develop appropriate performance goals, including cost and utilization goals, that can determine if the managed care plans are contributing adequate value to the Utah Medicaid program. Utah Medicaid should then hold the plans accountable to these goals.	In process	In process	Changes due to S.B. 180 should help accomplish these goals. Specific utilization targets and goals should be central to the management of managed care (or the new accountable care model).
We recommend that Utah Medicaid help facilitate the sharing of good health management practices between plans.	In process	Implemented	For the past 2 years, Utah Medicaid has been meeting with the plans on a regular basis. Some sharing of good health management practices does occur in these meetings.
We recommend that the Legislature direct Utah Medicaid to report to them on cost savings obtained through future contracting with the managed care plans.	In process	Implemented	The Legislature has passed S.B. 180, which will require more cost sharing information. They have also sought cost savings information through our follow-up reports.

All but one of the recommendations from Chapter III of the managed care audit have been implemented.

Of note in this section is the need to establish and monitor specific cost utilization goals. Last year Utah Medicaid started to address this need by establishing specific goals for Cesarean sections. Utah

Medicaid must continue to be diligent in setting procedural goals and tracking the success of these goals.

Managed Care Oversight Is Improving

Utah Medicaid continues to improve its oversight over managed care plans. Last year, most oversight-related recommendations were still categorized as in process. This year, many additional recommendations have been implemented, and the passage of S.B. 180 will further help in the implementation of these recommendations.

Oversight Improvements Have Been Made

Utah Medicaid has begun to hold its managed care plan contractors more accountable for reaching the lowest achievable costs. A key aspect to this accountability was to have a contracted actuary review the risk-adjusted relative costs of the plans so Utah Medicaid would know which plans were achieving the lowest costs.

Utah Medicaid has continued actuarial studies to more fully understand who is the lowest cost managed care plan, but must continue to drive down costs to the lowest obtainable levels.

As part of the 2010 audit, we contracted with Utah Medicaid's actuary to provide information on risk-adjusted relative costs for the three Utah Medicaid managed care plans. Utah Medicaid has continued this report and now better understands who the lowest-cost provider is. We have also seen more of a desire on the part of Utah Medicaid to ensure that plans are driven down to the lowest cost. To fully achieve cost-saving estimates cited in our original report, Utah Medicaid must continue to use all the available tools to drive down costs to the lowest obtainable levels. S.B. 180 contains provisions that will help in the establishment and implementation of this goal. Figure 3.4 shows the status of the recommendations in Chapter 4 of the Managed Care audit.

Figure 3.4 Status of Recommendations from Chapter IV, Report #2. Three recommendations from this chapter are still in process. This is due to changes that occurred from S.B. 180. It appears that Utah Medicaid is actively pursuing the implementation of these recommendations. (Recommendation color code: gray – Legislature and green – DOH)

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that Utah Medicaid apply risk-adjusted relative costs to their analysis of health plans to gain potential cost savings.	In process	Implemented	Utah Medicaid's contracted actuary is now doing this analysis and using it as part of the rate negotiations.
We recommend Utah Medicaid determine an acceptable cost-level for the plans and hold the plans to that level.	In process	In process	S.B. 180 will help establish a cost level for the plans. Utah Medicaid must be sure to establish the cost-level at an appropriate rate that will ensure cost savings and adequate service delivery.
We recommend Utah Medicaid determine the actual amount and rate of administering the Select Access plan, managing claims, overseeing the health plans, and other cost centers so that it can be used in further analysis.	In process	In process	S.B. 180 will likely change the Select Access plan to a fully capitated plan, which would nullify the need for this recommendation. However, Medicaid should still be aware of its costs for administering the fee-for-service plan.
We recommend that Utah Medicaid incorporate prior authorization data in their monitoring of the health plans.	In process	In process	Utah Medicaid reported that their contracted actuaries plan on using this data in the future.
We recommend that the Legislature direct Utah Medicaid to report to them on cost-savings obtained through improved managed care contracting, and follow-up to ensure that the fullest, appropriate, cost-savings potential is realized.	In process	Implemented	The Legislature passed S.B. 180, which will require more cost saving information. They have also sought cost savings information through our follow-up reports.

Three recommendations from Chapter IV of Report #2 are still in process due to changes associated with S.B. 180.

S.B. 180 should help ensure managed care costs are contained.

S.B. 180's provisions should help ensure costs are contained. For example, S.B. 180 would limit the rate of growth in per-patient-per-month General Fund expenditures for the Medicaid program to the rate of the growth in General Fund expenditures for all other programs. Utah Medicaid placed this provision in a waiver that has been presented to federal Medicaid, or CMS.

Quality-of-Care Oversight Is Improving

In addition to recognizing the need for cost control, the 2010 Managed Care audit cited concerns with the lack of meaningful quality-of-care oversight. The January 2010 audit states:

> The primary aim of the Division of Health Care Financing (HCF or Utah Medicaid program) is compliance with federal requirements. As a result, we believe management has spent little time developing and implementing best practices for good management. While adherence to federal requirements is essential, HCF is also given the authority to customize the Medicaid program. We believe that the Bureau of Managed Health Care (BMHC) within HCF can provide more meaningful oversight to improve care delivery.

It appears that quality of care oversight efforts have improved.

It appears that quality-of-care oversight is improving. The prior follow-up review of Utah Medicaid found that three out of five of the recommendations directed at quality-of-care oversight were implemented, and the remaining two were in process. All five recommendations have now been implemented.

We encourage Utah Medicaid to continue to be inventive with its oversight efforts to ensure that adequate, meaningful oversight over quality of care is achieved. This will continue to grow in importance as managed care moves to accountable care and more Medicaid beneficiaries move toward this style of care. Figure 3.**5** shows the status of our recommendations from Chapter 5 of the Managed Care audit.

Figure 3.5 Status of Recommendations from Chapter V, Report #2. This follow-up review finds that all five recommendations directed at quality of care oversight have been implemented.
(Recommendation color code: green – DOH)

Recommendation	2010 Status	2011 Status	2011 Explanation
We recommend that the Bureau of Managed Health Care conduct a cost/benefit analysis of collecting similar health quality information, including HEDIS measures, for the Select Access plan.	Implemented	Implemented	No change
We recommend that the Bureau of Managed Health Care should establish a standard for quality of care appropriate for Utah.	In process	Implemented	Utah Medicaid created a State Quality Committee (SQC) to select quality standards and review MCOs' quality outcomes annually.
We recommend that the Bureau of Managed Health Care require the *Annual External Quality Review Report for Prepaid Inpatient Health Plans* to include a full summary of all results of the corrective action plans.	Implemented	Implemented	No change
We recommend that the Bureau of Managed Health Care independently validate, through sampling, some of the information contained within the quality improvement reports (plan description, work plan, and work plan evaluation).	In process	Implemented	Utah Medicaid implemented an audit process to independently validate MCOs' quality improvement reports through review of supporting documentation
We recommend, for comparison purposes, that the Bureau of Managed Health Care ensure that the managed care plans adhere to their required format for quality improvement reporting.	Implemented	Implemented	No change

All five recommendations aimed at improving managed care quality-of-care oversight have been implemented.

In our January 2010 audit, we were encouraged by the quality-of-care information collected from managed care organizations (MCOs) but were concerned, in part, with the apparent lack of quality-of-care outcome targets and data validation. In 2010, our recommendations concerning these two areas were in process, while the other three recommendations had been implemented. Utah Medicaid has now implemented actions that satisfy the outstanding recommendations. For example, Utah Medicaid has created a State Quality Committee (SQC) that has worked with stakeholders to select 10 core quality-of-care performance measures in which MCOs are instructed to be at or above the 75th percentile nationally. The minimum expectation for all other quality of care measures is for MCOs to rank above national averages. The SQC is expected to meet annually.

Utah Medicaid implemented a State Quality Committee responsible for monitoring quality of care targets.

Medicaid Must Continually Look for Cost-Saving Options

The original report's sixth chapter identified ways that Utah Medicaid could be more proactive in developing cost-saving programs proven to be effective in other states. Utah Medicaid has reviewed several of these programs and is in the process of implementing some of them. We are encouraged by these results and hope that Utah Medicaid continually looks for new, inventive, and proven ways to save Medicaid funds.

For example, we recommended that the Legislature and Utah Medicaid move away from a percent-of-charges to a fixed-fee schedule. Utah Medicaid implemented this recommendation on September 1, 2011, and as a result, Utah Medicaid reports saving about $5 million annually from these changes. Figure 3.6 shows the status of our recommendations in Chapter 6 of the Managed Care audit.

Figure 3.6 Status of Recommendations from Chapter VI, Report #2. All but one of the recommendations from this chapter have been implemented. The one recommendation that has not been implemented deals with the need for Utah Medicaid to research best practices from other states' emergency room utilization reduction programs.
(Recommendation color code: green – DOH and blue – OIG)

Recommendation	2010 Status	2011 Status	2011 Explanation
The Department of Health should frequently review emergent ER claims to verify the appropriate diagnosis is used to help ensure expected cost savings are realized.	In process	Implemented	This recommendation was pointing to program integrity, which is now OIG. The OIG reports conducting reviews at four hospital systems and is currently going through the hearing process on these reviews.
Utah Medicaid should monitor results of ER utilization grants to determine which grants could feasibly transfer to Utah hospitals.	In process	In process	The federal ER grant has expired, but the Legislature extended the grant for Utah Medicaid. Utah Medicaid now needs to research best practices from other states and implement those they feel will be successful.
Utah Medicaid should ensure that surgical center rates are being paid correctly and should consider adding to the list of defined reimbursement procedures as a way of controlling costs.	Implemented	Implemented	No change
The Legislature and Utah Medicaid should consider moving away from a percent of charges to a revenue-code fee schedule.	In process	Implemented	Utah Medicaid reports the full transition was completed on September 1, 2011. They report a $5 million annual savings from this change.
Utah Medicaid should consider using more preventive care and case management through cost-saving programs such as medical homes and disease management.	In process	Implemented	Utah Medicaid has considered the use of more preventive care and case management and has several programs in the works.
Utah Medicaid should determine potential cost savings that could be realized through HOAs, HIPP, and other programs, and implement or expand them if savings are shown.	In process	Implemented	Utah Medicaid is currently achieving cost savings through its HIPP program. They also expressed an interest in reviewing new programs to achieve cost savings.

All but one of the recommendations from Chapter VI of the managed care audit have been implemented.

To implement the recommendation on using more preventive care and case management, Utah Medicaid has started a Children's Healthcare Improvement Collaboration (CHIC), which will focus on preventative care and case management. This program focuses on three broad goals:

- **Improvement Partnership:** Utah Medicaid is working with the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) and the National Improvement Partnership Network (NIPN) to develop an Idaho improvement partnership. So far, the project has held a pediatric asthma learning collaborative.
- **Health Information Technology:** Utah Medicaid is working to increase the availability and functionality of health information technology for practices serving children. This will help providers and families of children with special health care needs better access information.
- **Medical Home Demonstration:** Utah Medicaid reports that the project is currently supporting the efforts of 12 practices in Utah.

Utah Medicaid has implemented programs for youth and high risk groups to help increase cost savings.

Utah Medicaid also reports it is in the process of beginning a diabetes management initiative. It hopes to have the program up and running in January 2012. The program will focus on four Medicaid high-risk populations:

- Disabled adults and children with diabetes
- Adults unable to self-manage diabetes appropriately
- Those whose disease is not well controlled with conventional management
- Children and adults with a strong history of diabetes or pre-diabetes.

These individuals will be identified using Medicaid claims data containing specific diagnostic codes. The groups will be provided special tools and education designed to benefit their specific risk group. The plan also includes a diabetes call center that will utilize current staff as diabetes coaches.

Chapter IV
Follow-Up of Report 2010-16: *A Performance Audit of Utah Medicaid Provider Cost Control* (December 2010)

Report #2010-16, *A Performance Audit of Utah Medicaid Provider Cost Control*, December 2010 was an outgrowth of our August 2009 report that also dealt with fraud, waste, and abuse. The 2009 report outlined control weaknesses in Utah's Medicaid program (the status of recommendations from that report can be found in Chapter II). That report (August 2009) also listed control deficiencies that limited the state's ability to reduce fraud, waste, and abuse, and estimated possible cost savings that could be obtained by improving controls. The scope of the provider cost control report (December 2010) was to review specific cases of Medicaid fraud, waste, and abuse that showed the need for increased controls.

The provider cost control audit, released in December 2010, reviewed specific instances of fraud, waste, and abuse in Utah's Medicaid program.

We are encouraged by the response current Department of Health (DOH) management has given to the recommendations listed in this chapter. It appears they have striven to improve processes and systems. As previously reported in Chapters II and III, the implementation of our recommendations has led to significant cost savings. Utah Medicaid also reports cost savings from the implementation of recommendations reiterated in this chapter. Specifically, the recommendation to revalue pricing on some drugs has, according to Utah Medicaid, produced cost savings of about $3.4 million as illustrated in Figure 4.1.

One recommendation dealing with pharmacy prices resulted in about $3.4 million in savings.

Figure 4.1 Pharmaceutical Cost Savings. We recommended that an analysis of pharmacy drug prices occur to determine what potential cost savings were available. Utah Medicaid conducted this analysis and reported the below cost savings.

Category	Estimated Annual Cost Savings
Revaluation of Pharmacy MAC Pricing	$3.4 million

Source: Utah Medicaid Program

In addition to cost savings, other program improvements have also been made as a result of the audit recommendations being implemented.

This chapter provides the status of the recommendations from the 2010 provider case review audit. Most of the recommendations from this report have been implemented. Below is a summary of the status of each of our recommendations:

67 percent of the recommendations have been implemented. The other 33 percent are in process of being implemented.

- Implemented – 6 (67 percent)
- In process – 3 (33 percent)

Recognition of Fraud, Waste, and Abuse in Utah Has Improved

When the August 2009 report was released, the DOH questioned the degree to which higher recoveries in Utah were possible. The December 2010 audit on provider cost control addressed the department's position by reviewing some recognized high risk areas with potential for fraud, waste, and abuse.

One such area was medical provider billing practices, or what are known as evaluation and management (E&M) codes. This test was provided by the Texas Office of Inspector General (Texas OIG) over Medicaid. The Texas OIG said that upcoding (overcharging) can be common due to the lower reimbursement amounts in Medicaid programs. Our review found the following incorrect billing practices:

One provider review revealed that 99 percent of sampled claims could not be substantiated.

- **Provider 1 – Salt Lake Health Clinic of Utah:** This is a DOH- owned and -operated health clinic. The independent review found that 99 percent of the sampled 99214 and 99215 coded claims could not be substantiated at the level billed.
- **Provider 2 – A private health clinic located in the Salt Lake valley:** A review by Program Integrity nurses found that 88 percent of claims could not be substantiated at the level billed.
- **Provider 3 – Claims submitted by an individual physician at a different private health clinic:** These claims were reviewed by the Program Integrity nurses. The nurses found that 97 percent of this physician's claims were incorrectly billed.

Accordingly, the recommendations listed in Chapter II of the December 2010 report were focused on providing more transparency and accountability with DOH's fraud, waste, and abuse control efforts. We also recommended that more training be given to

healthcare providers. As Figure 4.2 shows, both recommendations from this chapter have been implemented.

Figure 4.2 Recommendations from Chapter II, Report #3. DOH and the OIG have implemented both recommendations from this chapter. (Recommendation color code: green – DOH and blue – OIG)

Recommendation	2011 Status	2011 Explanation
We recommend that the Department of Health, as required in ***Utah Code***, regularly report to the Legislature regarding the progress that is being made in avoiding and recovering fraud, waste, and abuse in Utah Medicaid.	Implemented	A joint report with DOH and OIG was presented to the Legislature during the Legislature's October 2011 interim meetings.
We recommend that Department of Health continue to facilitate state-wide Medicaid provider training of frequently used or potentially abused codes to help promote cost avoidance.	Implemented	Program Integrity (now the OIG) held a series of training meetings with the provider community on the need for correct billing.

DOH management appears ready to help confront the challenges of identifying and addressing fraud, waste, and abuse in Utah Medicaid. Clearly DOH has put effort into the implementation of these recommendations. We encourage the DOH and the Office of Inspector General (OIG) to continue their training efforts to help control incorrect provider billing.

DOH management appears ready to help confront the challenges associated with fraud, waste, and abuse.

Efforts to Control Utah Medicaid Payment Systems Are Ongoing

The December 2010 report also found that Utah Medicaid's identification and fund recovery system is hindered by system design problems and insufficient policies and procedures. Consequently, internal systems can unintentionally allow waste and abuse to occur in the Utah Medicaid program.

For example, we reviewed policies and practices of Utah Medicaid's pharmacy program. We recommended that the Utah Medicaid program take steps to ensure it is getting the best available price on prescription drugs. To date, the Utah Medicaid program has identified $3.4 million in savings, and has also issued a request for

Based on our recommendation, Utah Medicaid has identified $3.4 million in pharmacy savings.

proposals (RFP) to review the costs and benefits of contracting with an independent firm to manage prescription costs. Further, the OIG is in the process of beginning its own efficiency review of the pharmacy program. Figure 4.3 shows the status of recommendations made in this chapter of the report.

Figure 4.3 Recommendations for Chapter III, Report #3. Two recommendations from this chapter have been implemented and the other three are in process of being implemented. (Recommendation color code: green – DOH and blue – OIG)

Recommendation	2011 Status	2011 Explanation
We recommend that Utah Medicaid report all collections, recoveries, and overpayments that they process to the office of Internal Audit and Program Integrity (OIAPI) for tracking and reporting.	Implemented	The report was provided to the OIG (previously OIAPI). Results of this report can be found in Chapter II of this report.
We recommend that the Office of Internal Audit and Program Integrity (OIAPI) conduct an analysis on pharmacy maximum-allowed-costs (MAC) policies and practices to determine the potential cost savings if Medicaid changes policies and MAC prices.	In process	The OIG (previously OIAPI) reports that they are in the process of beginning this review. However, Utah Medicaid has completed a major update to MAC pricing that was effective on July 1, 2011. Estimated annual savings from this update are expected to be about $3.4 million. The OIG should still review this process to determine if further savings are possible.
We recommend that Utah Medicaid, in conjunction with the Office of Internal Audit and Program Integrity (OIAPI), review the cost and benefits of contracting with a firm to manage prescriptions costs.	In process	An RFP has been issued. Information obtained from the RFP will be used to review the cost and benefits of contracting with a firm to manage prescription costs.
We recommend that the Office of Internal Audit and Program Integrity (OIAPI) should continually audit for internal weaknesses, including payment and policy weaknesses. OIAPI should make any findings available to the Legislature on an annual basis and provide the Legislature a status report on corrective action that the Department of Health takes.	In process	OIG is ramping up their audit resources. In the future they will more aggressively audit for internal weaknesses, including payment and policy weaknesses.
We recommend that Utah Medicaid change its dental cleaning policy to be in line with other accepted insurance policy standards.	Implemented	The dental cleaning policy was changed and is now in effect.

The OIG is in the process of ramping up its audit resources to engage in more oversight and review of the Utah Medicaid program.

The newly created OIG reported that they are actively working on identifying internal control weaknesses in Utah's Medicaid program and making appropriate corrective recommendations. However, their work is currently limited by high staff turnover. The inspector general has only been in office about five months and is actively engaged in looking for additional, well-qualified staff to be fully engaged in internal review of the Utah Medicaid program next year. The OIG plans to follow the recommendations and make its findings available to the Legislature on an annual basis; this information should include a status report on corrective actions.

The OIG's work has been limited due to staff turnover.

The Legislature, Acting on Independence Concerns, Created the Office of Inspector General

The December 2010 report examined the independence of DOH's oversight functions over program integrity and audit and stated:

> The structure of the DOH audit and Program Integrity functions has demonstrated past and continuing independence problems that lead us to question if the current structure is capable of providing adequate oversight to the over one billion dollars in Utah's Medicaid program. Other states that have implemented successful inspector general offices report substantial cost savings once independence was achieved.

Consequently and as previously discussed, we recommended the creation of an independent OIG office that could provide oversight to the integrity of the Medicaid budget and program. The Legislature created this office in the 2011 Legislative General Session. Figure 4.4 provides the status of the recommendations from Chapter IV of our December 2010 report.

Figure 4.4 Recommendations for Chapter IV, Report #3. Both recommendations from this chapter were to the Legislature. The Legislature has acted on both of these recommendations.
(Recommendation color code: gray – Legislature)

Recommendation	2011 Status	2011 Explanation
We recommend that the Legislature consider establishing independence standards for Medicaid Program Integrity operations.	Implemented	H.B. 84 sponsored by Representative David Clark created an independent Office of Inspector General. This legislation included a provision for the development of standards based on sound principles from respected organizations such as the US Government Accountability Office.
We recommend that the Legislature consider creating an Office of the Inspector General, based on sound practices identified in this report, with oversight responsibility for Medicaid programs and funds.	Implemented	H.B. 84 of the 2011 General Session passed both bodies of the Legislature unanimously and was signed by the governor. The bill took effect on July 1, 2011.

We recommended the creation of an independent OIG. The Legislature created this office in the 2011 General Session.

As previously stated, the Legislature created the OIG in the 2011 Legislative General Session. The office is still in its infancy and has not yet fully structured its programs, but it appears to be appropriately seeking recovery of wrongly paid claims.

Chapter V
A Follow-Up of Utah Medicaid's Implementation of Audit Recommendations
(December 2010)

Last year, at the request of the Legislative Audit Subcommittee, we conducted an in-depth follow-up (report #2010-14) of our first two Medicaid reports (reports #2009-12 and #2010-01). Two additional recommendations to the Utah Department of Health (DOH) were made in that follow-up that dealt with automating provider disenrollment and utilizing statistical extrapolation. Figure 5.1 shows the status of those recommendations.

Two additional recommendations to DOH were made in last year's in-depth follow-up and are reported in this chapter.

Figure 5.1 Recommendations from Chapter 2, Report #4. Both recommendations from this chapter have been implemented. (Recommendation color code: green – DOH)

Recommendation	2011 Status	2011 Explanation
We recommend that the Utah Medicaid program determine the cost-benefit of automating the disenrollment of inactive providers after 24 months, and track results of any disenrollment.	Implemented	Utah Medicaid implemented this recommendation which resulted in the removal of about 460 provider group practices, or about 800 individual providers.
We recommend that the Department of Health Implement an administrative rule allowing Program Integrity to use statistics in their cost recovery efforts.	Implemented	This rule became effective on December 1, 2011.

Both recommendations from last year's follow-up have been implemented.

In the 2010 follow-up report, we recommended that the provider enrollment function within the Utah Medicaid program review the feasibility of automating provider disenrollment. This recommendation was based on criteria gathered from seven states that all report that providers are disenrolled if they do not submit any claims for an extended period of time (12, 18, or 24 months).

This process of automatic disenrollment helps ensure program integrity in that it allows the Utah Medicaid program to better manage and understand the active providers in the program. Utah

Medicaid implemented this recommendation, which resulted in the removal of about 460 provider group practices, or about 800 individual providers.

Recommended in last year's follow-up was a repeat recommendation to DOH to write a rule allowing for extrapolation.

Also recommended in last year's follow-up was a repeat recommendation from our first report on Medicaid fraud, waste, and abuse. This recommendation dealt with the need for the DOH to write a rule allowing for extrapolation in provider audits. The follow-up audit states:

> The DOH needs an administrative rule allowing for the use of statistics in program integrity audits. Other states' program integrity offices believe that the use of statistically valid extrapolation is a necessary tool both in achieving cost recoveries and in aiding cost avoidance. Some of these states have reported that substantial recoveries cannot occur without the use of extrapolation due to the limits in staff resources.
>
> We believe Program Integrity may benefit from the use of competent and proven statistical methodologies in the course of their audits. In addition, some other state program integrity offices have indicated that an administrative rule is the typical venue to approve the use of statistics in program integrity auditing.

The DOH implemented a rule in December of 2011 that allows for extrapolation.

The DOH went through the rule making process that would allow for the use of extrapolation. It became effective on December 1, 2011.

Agency Response

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State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health
Executive Director's Office

W. DAVID PATTON, Ph.D.
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January 11, 2012

Mr. John M. Schaff, CIA
Legislative Auditor General
315 House Building
PO Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Schaff:

Thank you for the opportunity to review and respond to the legislative audit titled "An In-Depth Follow-Up of Utah Medicaid's Implementation of Audit Recommendations." (Report No. 2012-03). We in the Department of Health appreciate the work you and your staff performed in the review of our implementation efforts of the audit recommendations from all of the recent Medicaid audits.

The Department has put substantial effort into implementing these recommendations and is pleased that your report indicates that seventy-five percent of the recommendations assigned to the Department have been implemented and the remainder are all in the process of being implemented. Of those recommendations that are in the process of being implemented, the vast majority will be resolved when the new Accountable Care Organization (ACO) waiver proposal, currently being reviewed by the federal government, is approved and implemented later this year.

Although the Department has implemented all of the recommendations related to waste, fraud and abuse controls from the first audit, we will continue to work closely with the Medicaid Fraud Control Unit (MFCU) in the Attorney General's Office and the newly created Office of the Inspector General to be diligent in the prevention and detection of fraud, waste and abuse in the Medicaid program.

Additionally, the Department has set as one of its strategic priorities transforming the Medicaid program. The Department plans to use the momentum from the new ACO waiver to develop into a national leader for innovative program reforms. These reforms will include developing payment reform models, increasing enrollees' participation in their healthcare and integrating service delivery systems. The ultimate goal of these reforms is to obtain quality health outcomes with the most efficient use of funds.

Again, we thank you for your time and efforts in performing this in-depth review.

Sincerely,

W. David Patton, Ph.D.
Executive Director

UTAH DEPARTMENT OF HEALTH

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Office of the Inspector General

STATE OF UTAH

LEE WYCKOFF

Inspector General

January 11, 2012

Mr. John Schaff
Legislative Auditor General
315 House Building
Salt Lake City, Utah 84114

Dear Mr. Schaff,

Thank you for the opportunity to respond to the audit entitled "An In-Depth Follow-Up of Utah' Medicaid's Implementation of Audit Recommendations" (Report No. 2012-3). We accept the recommendations made to this office, and are anxious to work toward making the recommended changes.

We appreciate the effort and the professionalism of you and your staff during this audit period. We look forward to continued cooperation as we strive to implement all of the listed recommendations. As the report shows, all of our recommendations are implemented or in process toward full implementation.

Since the creation of the Inspector General's Office in July of 2011 we have taken our role in providing oversight of the Medicaid program on behalf of the Utah taxpayer seriously. We have begun to structure our team with both retained and new individuals that will provide a significant return on investment for the State. We are also writing rules for our new office to dictate how we will implement our responsibilities outlined in our governing laws. The Medicaid Inspector General's Office is committed to minimizing fraud, waste and abuse, through effective and efficient oversight over the state Medicaid program.

Thank you for your time and consideration on this audit.

Lee Wyckoff, CIA, CPA
Inspector General